Memorandum

SUBJECT: CorHealth COVID-19 Stroke Memo #2- **RECOMMENDATIONS FOR AN ONTARIO APPROACH TO THE PROVISION OF STROKE REHABILITATION DURING COVID-19**

TO: Stroke Rehabilitation Stakeholders (Acute, Inpatient Rehabilitation, Out-Patient and In-Home Care)

FROM: Office of the CEO, CorHealth Ontario

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DISCLAIMER: The information in this document represents general guidance based on current practice and available evidence. The document was developed by provincial clinical experts, reflecting best knowledge at the time of writing, and is subject to revision based on changing conditions and new evidence. This information is *intended to* be "guidance rather than directive," and is *not meant to replace clinical judgment, regulatory body requirements, organizational, or hospital policies*. Reference to Infection Prevention and Control (IPAC) or Personal Protective Equipment (PPE) in this document should not replace or supersede the IPAC and PPE protocols or directives in place at your hospital.

Recommendations for an Ontario Approach to the Provision of Stroke Rehabilitation during COVID-19

PREAMBLE

COVID-19 is an unprecedented crisis and a poses significant risk to the community as the landscape is rapidly evolving. The Ministry of Health has requested that all hospitals ramp down non-essential services, elective surgeries and other non-emergent clinical activity. CorHealth Ontario has been engaging with stroke experts and stakeholders across the province to discuss how best to preserve health care capacity, in light of increasing COVID-19 cases requiring health care. The following guidance and recommendations reflect advice from this engagement.

GUIDING PRINCIPLES

1. Keeping front line health care providers healthy and patients protected is vital.
2. Minimizing the impact of COVID-19 on the mortality and morbidity of patients with stroke is a priority.
3. Aligning with province- and organization-specific infection prevention and control policies and protocols is important.
4. Promoting clinical activities aimed at preserving health service resources (i.e. health care human resources, personal protective equipment, procedure rooms, Intensive Care Units, Emergency Departments) is a priority.
5. Ensuring that patients continue to have access to urgent and/or essential care across the continuum.

BACKGROUND

Stroke is a leading cause of adult disability in Canada. Stroke rehabilitation services play a critical role in offering people with stroke the best opportunity for optimal recovery. Strong evidence indicates that any form of continuing rehabilitation therapy is superior to no additional therapy and is associated with significantly reduced odds of a poor outcome, as well as greater improvements in function and mood. For

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every 100 persons with stroke in the community receiving rehabilitation, 7 patients are spared a poor outcome.[1]
Stroke rehabilitation also plays a critical role in supporting patients to transition safely from hospital to home. Stroke rehabilitation has been associated with a reduction in the severity and number of falls, as well as a reduced potential for hospital readmission.[2] As such, stroke rehabilitation plays a critical role in the management of patient flow through the healthcare system and in the prevention of recurrent hospitalization. It is therefore critical that urgent rehabilitation services continue to operate as much as possible during the COVID-19 outbreak.

Regulated health professionals operating outside of the in-patient hospital sector are required to adhere to the restrictions put forward by the province of Ontario to reduce contact between people and to stop the spread of COVID-19. For further guidance, refer to section 15 under the *List of Essential Services* posted on the Government of Ontario website. In addition to this document, health care professionals should follow the requirements put forward by their respective regulatory body. This document aims to provide further clarification on the components of stroke rehabilitation that may align with the provincial/regulatory college's definitions of urgent/essential services.

RECOMMENDATIONS

1. HUMAN RESOURCE CAPACITY

1.1. It is important that organizations and/or stroke regions develop capacity/contingency plans to ensure that health professionals (e.g. OT, PT, SLP, SW) are available to deliver essential/urgent stroke rehabilitation care in the inpatient, outpatient and community setting.

1.1.1. Ideally stroke rehabilitation should be delivered according to best practice (i.e. by professionals with stroke expertise). If individuals with stroke expertise are unavailable, other healthcare providers may be considered with appropriate support (e.g. stroke training/knowledge development).

2. IN-PATIENT (ACUTE/REHAB) PHASE

2.1. Access and provision to inpatient stroke rehabilitation services should remain a priority as per current best practice and quality-based procedure recommendations.[2,3] This should include timely assessment and triage to post-acute rehabilitation.

2.2. Priority for in-patient rehabilitation should focus on rehabilitation intensity, safety (including accessibility of home, equipment needs, etc.) and basic functional activities of daily living to promote safe and timely transition to the community.

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[1] Outpatient Service Trialists. Therapy-based rehabilitation services for stroke patients at home. Cochrane Database of Systematic Reviews 2003, Issue 1. Art. No.: CD002925. DOI: 10.1002/14651858.CD002925.
[2] Robert Teasell (First Author), Nancy M Salbach (Co-First Author)., et al., on behalf of the Canadian Stroke Best Practices Advisory Committee. Canadian Stroke Best Practice Recommendations, 2019; Ottawa, Ontario Canada: Heart and Stroke Foundation
[3] Health Quality Ontario; Ministry of Health and Long-Term Care. Quality-based procedures: clinical handbook for stroke (acute and postacute). Toronto: Health Quality Ontario; 2016 December. 132 p. Available from: http://www.hqontario.ca/evidence/evidence-process/episodes-of-care#community-stroke.

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2.3. Some patient characteristics leading to higher discharge risks may require additional inpatient rehabilitation support and planning.
2.4. Virtual care options for psychosocial support during in hospital stay should be considered as a mode to enable visitation and patient engagement.
2.5. Virtual care options for rehabilitation may be considered as a potential strategy to facilitate faster transition to the community provided that the level of intensity can be maintained and aligned with the virtual care recommendations below.

3. SUPPORTING TRANSITIONS TO COMMUNITY

3.1. Prior to and in anticipation of discharge to community, the hospital team (inpatient rehabilitation or acute care) should ensure that the patient-specific service requirements are currently available within the community. This planning may include a conversation between healthcare providers, patients and caregivers to understand the feasibility of virtual care, the need for in-person visits and/or the identification of other potential strategies to address rehabilitation needs.
3.2. Discharge Planning should be started as soon as possible and include direct communication to the next level of care prior to discharge to ensure that the patient's urgent community rehabilitation needs are identified, shared with the accepting service provider and a suitable plan is in place to meet essential rehabilitation needs.
3.3. Patients/caregivers ideally will be provided with a point of contact for the accepting service provider prior to discharge and/or be provided with timely follow up call from the inpatient team to ensure continuity of care.

4. DELIVERY OF ESSENTIAL/URGENT STROKE REHABILITATION (OUTPATIENT/HOME/COMMUNITY)

4.1. Essential/urgent outpatient/in-home stroke rehabilitation services should continue to operate during the current COVID-19 outbreak and should optimize the use of virtual care options when possible (a list of potential remote/virtual care tools can be found at the CorHealth Resource Centre (scroll to "Virtual Rehabilitation Resources section").

4.1.1. Prior to providing any community in-person rehabilitation services, a discussion should occur between the therapist and the patient (and caregiver if applicable) to make an informed and shared decision regarding the specific risks and benefits of receiving or not receiving urgent rehabilitation services through in-person delivery, virtual care or other options.
4.1.2. Health Professionals should follow organizational and IPAC policies with respect to the provision of in-person visits.
4.1.3. In many cases the provision of in-person rehabilitation is the only appropriate option to support a patient-centered approach to care (i.e. in-person physical assessment/treatment is essential to the service). While the following is not an exhaustive list and requires clinical judgement, in-person services should be considered for the following stroke patients:

- New onset of stroke with a recent discharge from an acute care or inpatient rehabilitation facility with any of the following:
    - Clients whose essential functional movement require assessments, treatments and recommendations (e.g. gait aid prescription, practice with transfers, activities of daily living equipment set up) to prevent falls, hospital readmissions and to ensure basic home safety/accessibility.

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- Clients with hemiparesis require therapy, including prescription of key functional activities and specific exercises to facilitate recovery, maintain and improve movement, prevent learned non-use in their affected limb(s)/trunk.
- Clients with limb paresis/dysfunction require therapy, including prescription of specific exercises prevent muscle contractures and pain due to increased tone.
- Clients with language or swallowing difficulties that impact safety require a Speech-Language Pathology assessment, treatment and recommendations regarding essential communication strategies, prevention of aspiration and subsequent complications such as pneumonia.
- Clients experiencing cognitive and/or perceptual difficulties that require treatments to progress independence and safe living in the home.
- Clients experiencing emotional distress (e.g. anxiety/depression) require counseling and supports to prevent further decline that may be caused by isolation or new medical/functional status post-stroke, if provision via virtual care is not possible.
- Clients requiring education on the use of new equipment (e.g. transfer bath bench, wheelchairs), particularly when cognitive and perceptual difficulties limit independence and/or there is no caregiver/family available to assist.
- Clients who are unable to or require further assessment regarding their ability to perform instrumental activities of daily living (IADLS).
- Clients where caregiver or family teaching is required to support rehabilitation goals.

- Stroke patients who experience a change in status may require in-person visits to assess and treat as indicated (i.e. skin integrity issues, change in seating/positioning, lack of progression in rehabilitation goals, move to a new home environment or change in status of caregiver support).

4.1.1.1. If the patient declines in-person rehabilitation care, the healthcare professional should discuss potential risks associated with not having the in-person rehabilitation and explore alternative therapy options.

4.2. If in-person visits are not feasible or appropriate in the current environment, alternative therapy options, such as virtual care should be considered for these patients.

4.2.1. Organizations should ensure that front line providers have access to the supports required to deliver effective virtual care (e.g. technology, training etc.).

4.2.2. Decisions to utilize virtual care must take into consideration both the feasibility of delivering the specific therapy needs; as well as individual patient characteristics (e.g. access to technology, caregiver supports). Refer to Appendix A for a more comprehensive list of considerations.

4.2.3. Prior to providing virtual care, detailed information regarding the potential privacy/security risks and the scope of care provision should be made available to the patient and verbal consent to provide care using virtual care electronic communication tools should be obtained and documented in the patient chart. An example template can be found at OntarioMD.

4.2.4. The need for in-person visits should be continually reassessed throughout the course of treatment.

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APPENDIX A: CONSIDERATIONS FOR USE OF VIRTUAL CARE

Virtual care has been defined as any "interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies (e.g. videoconferencing, telephone, email) with the aim of facilitating or maximizing the quality and effectiveness of patient care".[4p.3]

IN ADDITION TO CONSULTING PROFESSIONAL REGULATORY COLLEGE GUIDELINES, CLINICIANS SHOULD:

1. Consider if virtual care is a feasible means to deliver the rehabilitation intervention.
2. Consider patient access to technology and internet etc., and other practical limitations.
3. Consider if patient is able to participate independently or caregiver is able to provide assistance for both the safety of tasks during intervention and/or technical support.
4. Ensure and document consent considering that any electronic means cannot be 100% secure.
5. Ensure an environment that considers privacy for both yourself and the participant (e.g. are there others around in your office or does the client have a private space at their home/workplace).
6. Ensure an alternate way of contact (e.g. phone number) in case of technology failure, i.e. wifi out etc.
7. Ensure an emergency plan is in place (i.e. call 911 or local number if there is an incident such as a fall).
8. Be aware of the limitations of virtual care (e.g. inability to provide physical support, difficulty to perceive emotions, level of effort, etc.) and adapt therapy accordingly.

EXAMPLES OF ACTIVITIES THAT COULD OCCUR REMOTELY USING VIRTUAL CARE CONNECTIONS.

- Subjective assessment (patient / caregiver report)
- Observational assessment (video) of patient and home (physical environment)
- Cognition/Depression screening
- Patient Education
- Exercise and activity progression (some limitations)
- Self-Management Coaching/Advice (individual/group)
- Problem solving of ADLs and functional activities
- Patient monitoring
- Risk assessment
- Caregiver/family education/support
- Communication therapies (individual/group – some limitations)

[4] Canadian Medical Association. (n.d.). Virtual Care in Canada: Discussion Paper. Retrieved from https://www.cma.ca/sites/default/files/pdf/News/Virtual_Care_discussionpaper_v2EN.pdf

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